Anthem Individual Enrollment/ Change Application

P.O. Box 14024
Roanoke, VA 24038-4024
www.anthem.com

Anthem

New Enrollment: 1-866-478-4557
Current Members: 1-800-807-2919
Fax No. : 1-888-449-4807

For Office Use Only
Effective Date ____/____/____
Firm Division No.

Remember to Complete All Sections of this Application

PLEASE USE BLACK OR BLUE INK ONLY

1. Applicant Information

Please check appropriate item:
☐ **New Enrollment** ☐ **Change – Policy No.** _____ ☐ **Add/Remove Dependent – Policy No.** _____

Effective Date — If your application is approved, your coverage can start on the 1st of the month **after** the date we receive your application. The requested effective date is not a guarantee that the effective date will be the requested date in the event we agree to provide coverage.

Please choose the month you would like your coverage to start: Month _____

NAME (LAST/FIRST/MIDDLE INITIAL)			HOME ADDRESS (NUMBER AND STREET)
Male Female	DATE OF BIRTH MO. | DAY | YR.	SOCIAL SECURITY NUMBER	CITY/STATE/ZIP CODE
TELEPHONE NUMBERS HOME: WORK:			BILLING ADDRESS (IF DIFFERENT FROM HOME ADDRESS)
EMAIL ADDRESS			CITY/STATE/ZIP CODE

2. Medical Coverage

Anthem will enroll all eligible family members unless otherwise instructed below.

☐ I, the Applicant, request that Anthem not enroll any eligible applicants unless ALL family members qualify.

Plan Name, In Network Coinsurance, Deductible Options | **Optional Benefits**

Select ONE Plan...then select ONE Deductible and any optional benefits.

☐ **Anthem Premier PPO**
(20% coinsurance) ☐ $500 ☐ $1,500 ☐ $2,500
(0% coinsurance) ☐ $2,500 ☐ $3,500 ☐ $5,000 ☐ $7,500 ☐ $10,000

☐ **Maternity Rider**

☐ **Anthem SmartSense PPO**
(30% coinsurance) ☐ $750 ☐ $1,500 ☐ $2,500 ☐ $3,500 ☐ $5,000 ☐ $7,500
(0% coinsurance) ☐ $10,000 ☐ $12,000

☐ **Maternity Rider**
☐ **Enhanced Drug Benefit Rider**

HSA Compatible Plans

Select ONE Plan...then select ONE Deductible and any optional benefits.

☐ **Lumenos Health Savings Account Plus PPO**

Single
(20% coinsurance) ☐ $1,750
(0% coinsurance) ☐ $2,500 ☐ $4,000 ☐ $5,950

Family (more than one applicant)
(20% coinsurance) ☐ $3,500
(0% coinsurance) ☐ $5,000 ☐ $8,000 ☐ $11,900

☐ **Maternity Rider**

☐ **Yes,** I would like to establish a health savings account in conjunction with the HSA-compatible health plan I selected. Please forward my information to Anthem's banking partner. (Please fill in your social security number in Section 1.)

☐ **NO, I DO NOT** want to establish a health savings account in conjunction with the HSA-compatible health plan I selected above. Please **DO NOT** forward my information to Anthem's banking partner.

In New Hampshire, Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of New Hampshire, Inc., an independent licensee of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

3. Dependent Information

NAME (LAST/FIRST/MIDDLE INITIAL)	Add	Delete	Social Security Number	Sex	Date of Birth (mm/dd/yy)	Relationship to Applicant
Additional Adult (Spouse/Domestic Partner)			___ __ ____	☐ M ☐ F		
NOTE: IF ELECTING DEPENDENT COVERAGE, PLEASE LIST ALL ELIGIBLE CHILDREN UP TO AGE 26. You must complete a Certification for a Mentally or Physically Incapacitated Dependent Child form if your child is disabled, incapable of self-support, and age 26 or over. The form must also be completed by your physician.						
Dependent 1			___ __ ____	☐ M ☐ F		
Dependent 2			___ __ ____	☐ M ☐ F		
Dependent 3			___ __ ____	☐ M ☐ F		

4. Prior and Other Insurance Information - Please answer ALL of the following questions.

(1) Anthem Blue Cross and Blue Shield (Anthem) credits prior coverage toward the preexisting period of applicants who apply within 63 days after termination of qualifying prior coverage as required by law. In order to ensure that appropriate credit toward the preexisting period is obtained, please complete the following:

(a) Have you had coverage within 63 days of the date of application? ☐ Yes ☐ No

If yes, Name and address of Insurer _____

Policy Number _____ Name of insured _____ Date of Birth _____

☐ Single ☐ Two Person ☐ Family

Preexisting condition limitations do not apply to applicants under the age of nineteen (19), if applying for non-grandfathered coverage.

(b) Will medical coverage you are now electing replace another health insurance? ☐ Yes ☐ No

If yes, Name and address of Insurer _____

Group No. _____ Effective Date of Policy _____ End Date of Policy _____

Please note: If you currently have coverage, do not cancel prior to your acceptance into our plan.

5. Statement of Preferred / Standard Rate Acknowledgement

If preferred rates are not applicable but all eligibility requirements are met, Anthem will offer me, or any member to be covered under this policy a standard rate. If a standard rate is determined by underwriting, or if one or more of the individuals listed on my application do not meet the basic eligibility criteria, please indicate below how you would like us to proceed.

☐ Please continue with the enrollment process, subject to rate classification and eligible applicants. I understand that a lower rate may be available from the state's high-risk pool. If a lower rate is available, my producer or a representative from Anthem will contact me to discuss my options. Upon acceptance of the standard rate, I understand that I will receive a premium invoice from Anthem for the additional amount due.

If Anthem's standard rate is lower than the state's high-risk pool, I authorize Anthem to proceed with my enrollment and forward my membership materials to me.

☐ Before continuing the enrollment process, please contact me either through my producer or directly for authorization to continue at the standard rate .

☐ Do not continue the enrollment process at the standard rate.

6. Statement Of Premium Payment Acknowledgement

I understand that coverage most often becomes effective for eligible members on the first day of the month after submission of enrollment forms, provided that the Enrollment and Change Form and Health Statement form are completed accurately and in full, signed, dated and received by Anthem by the last day of the month prior to the effective date (unless the applicant requests a future effective date).

I understand that the submission of my enrollment forms are not a guarantee of coverage. Anthem will make the final determination about eligibility and rate classification by reviewing the information I submit.

Anthem may request further information about eligibility. If Anthem determines that I am not eligible for membership, I will be notified of the finding, coverage will not become effective.

If Anthem requests further information about eligibility and/or health status, my effective date of coverage may be delayed until Anthem receives all of the information requested. I will be notified of the effective date and any changes in premium offerings that may have occurred during the period of delay. If I do not respond to Anthem's request for further information within 24 days, coverage will not become effective.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE

(Only applies if this is a replacement policy)

According to the information furnished by you, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by Anthem. For your own information and protection, certain facts should be pointed out to you, which could affect your rights to coverage under the new policy.

(a) Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy for applicants age nineteen (19) and older applying for non-grandfathered coverage. This could result in a claim for benefits being denied or reduced under the new policy, whereas the same claim might have been payable under your present policy. Or, even though some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective.

(b) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(c) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found on an application may provide a basis for the company to deny claims that you have incurred and to refund your premium as though your policy had never been in force . After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

(d) Finally, before you terminate your present policy, be certain that your application for the new policy has been accepted by the replacing company.

Important: Please attach copies of any certification or other documentation of prior creditable coverage furnished by previous carriers or employers, if available. This will help us process your application.

I hereby authorize Anthem to institute the action indicated above. I understand that my Health Statement form is part of this application. To the best of my knowledge and belief, all of the information I provide is accurate and true. I will submit documentation of such to Anthem upon request. I understand that any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact may cause Anthem to terminate or void my coverage, in accordance with New Hampshire law.

7. ***Applicant's Signature***
(if applicant is under 18, parent or guardian signature required.) _____ Date: ____/____/____

Other Adult's Signature
(covered person 18 or older) _____ Date: ____/____/____

8. Authorization for Use of Protected Health Information

The following authorization must be signed by all of the following persons if they are applying for coverage or changing existing coverage:

- the applicant;
- the applicant's spouse/domestic partner; and
- any Dependent Child age 18 or over.

If the authorization is not signed by all of the persons listed above who are seeking coverage, the application may be returned to you as incomplete or acted upon without regard to any person whose required signature was not included. This Authorization will expire 24 months following Anthem Blue Cross and Blue Shield's acceptance of coverage, if not previously revoked.

By signing below:

I authorize Anthem Blue Cross and Blue Shield, or an agent, subsidiary or affiliate that has a business associate contract with Anthem Blue Cross and Blue Shield, to obtain any medical records or other health history information concerning me and any family member listed on my Application from any physicians, hospitals, pharmacies, other health care providers, pharmacy benefits managers, health benefits plans, health insurers, medical or pharmacy benefit administrators, MIB, Inc., formerly Medical Information Bureau (MIB), and/or insurance support organizations. I further authorize Anthem Blue Cross and Blue Shield to disclose protected health information it may collect about me to MIB, which may re-disclose such information to other insurance companies pursuant to the MIB information exchange.

I also authorize any physicians, hospitals, pharmacies, other health care providers, pharmacy benefits managers, health benefit plans, medical or pharmacy benefit administrators, and/or insurance support organizations to furnish any medical records or health history information concerning me and any family member listed on my Application to Anthem Blue Cross and Blue Shield, or an agent, subsidiary or affiliate that has a business associate contract with Anthem Blue Cross and Blue Shield. This information is needed to determine eligibility for coverage and Anthem Blue Cross and Blue Shield's acceptance of coverage requested for myself and/or any family members listed on my Application or so that a determination of coverage regarding a claim for specified benefits can be made. Any information obtained by Anthem Blue Cross and Blue Shield as a result of this authorization that is not related to the health history requested on the application and is not pertinent to Anthem's medical underwriting guidelines will not be considered when determining eligibility for coverage.

This authorization is subject to revocation at any time by written notice to Anthem Blue Cross and Blue Shield, except to the extent that Anthem Blue Cross and Blue Shield, has already taken action in reliance on this authorization. Any information received by Anthem Blue Cross and Blue Shield, pursuant to this authorization is subject to restrictions on disclosure to others as set forth under Federal and state laws.

IF LISTED ON YOUR APPLICATION, YOUR SPOUSE/DOMESTIC PARTNER AND EACH DEPENDENT CHILD OVER AGE 18 MUST SIGN BELOW.

SIGN HERE

Printed name of Applicant	Signature of Applicant* or Legal Representative X	Date of Birth / /	Date Signed / /
Printed name of Spouse/Domestic Partner	Signature of Spouse/Domestic Partner or Legal Representative X	Date of Birth / /	Date Signed / /
Printed name of Dependent Child over 18	Signature of Dependent Child over 18 X	Date of Birth / /	Date Signed / /
Printed name of Dependent Child over 18	Signature of Dependent Child over 18 X	Date of Birth / /	Date Signed / /

(or Custodial Parent's or Guardian's signature if applicant is under age 18)

A photocopy of this form will be as valid as the original.
You or an authorized representative have the right to receive a copy of this Authorization upon request.

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Anthem Blue Cross and Blue Shield New Hampshire Individual Markets Health Statement

This Health Statement is part of your application. Please submit this with your Enrollment and Change Form.

Visit our Web site at anthem.com

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New Hampshire Individual Markets Health Statement
Applicant and Family Information

When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

PART A YES NO

HAS ANYONE HAD HEALTH INSURANCE RATED WITHIN THE LAST 2 YEARS? ☐ ☐

IF YES, PLEASE SUBMIT DETAILS _____

PART B Are you or any person to be insured YES NO

1. currently disabled or unable to perform their normal activities within the past 2 years? ☐ ☐
2. been hospitalized, had surgery or been advised to have surgery within the past five years for any reason? ☐ ☐
3. currently pregnant? ☐ ☐
4. currently taking any medication? If yes, please specify medication and condition for which it is used: _____ ☐ ☐
5. smoked or used tobacco products within the past 2 years? ☐ ☐

PART C YES NO

In the past 5 years (unless otherwise specified) have you or any person to be insured ever had or been told by a health care provider they had or been medically counseled, consulted or treated for any of the following? (Check yes or no and circle the disorder) ☐ ☐

1. Chest pain, heart attack, heart murmur, heart trouble, other diseases of the heart, circulatory system or blood vessels, varicose veins, phlebitis, anemia or other disorder of the blood? ☐ ☐
2. Rapid, slow or irregular heart beat within the last 2 years? ☐ ☐
3. Cancer, tumor or lymph node enlargement? (Indicate type of cancer and location _____) ☐ ☐
4. Sexually transmitted disease within the last 2 years? ☐ ☐
5. Mental, emotional, behavioral or nervous condition or disorder of any kind? ☐ ☐
6. Brain disorder, neurologic problems, seizure disorder, any disorder of the central nervous system, stroke or paralysis? ☐ ☐
7. Alcohol or drug use, abuse and/or dependency? ☐ ☐
8. Medical diagnosis of AIDS (Acquired Immuno Deficiency Syndrome) or ARC (AIDS Related Complex)? ☐ ☐
9. Any disorder of the male/female reproductive organs including infertility and complications of pregnancy within the past 2 years? ☐ ☐
10. Back, neck, bone, joint problems, Lupus, arthritis or autoimmune disorder? ☐ ☐
11. Diabetes? If so, specify date of diagnosis, type of treatment, amount of medications (if any): _____ ☐ ☐

_____

Diagnosis or treatment by a health care provider within the past 5 years for:

12. any disorder of the stomach, intestines, gallbladder or esophagus? ☐ ☐
13. any disorder of the lungs or respiratory system or Tuberculosis? ☐ ☐
14. any disorder of the kidneys, bladder or urinary tract? ☐ ☐
15. any disorder of the liver or pancreas? ☐ ☐
16. any disorder of the endocrine system or glands? ☐ ☐

PART D

Within the last two years, have you or any person to be insured ever had, been told they had, consulted or treated by a health care provider for any of the following:

	YES	NO		YES	NO
1. Asthma	☐	☐	7. Lyme Disease	☐	☐
2. Bronchitis	☐	☐	8. Nose/Throat/Sinus problems	☐	☐
3. Skin problems/Allergies	☐	☐	9. Blood Pressure	☐	☐
4. Ear problems	☐	☐	If yes, please provide blood pressure readings for the previous 12 months _____		
5. Eye problems	☐	☐	10. High Cholesterol	☐	☐
6. Headaches/Migraines	☐	☐	If yes, please provide the results of the most recent lipid/cholesterol profile _____		

GIVE DETAILS TO ABOVE QUESTIONS ON NEXT PAGE (Part F). Simply listing the name of a primary physician or referring to a physician's name will not be considered a substitute for listing fully detailed answers to the questions on this and the following page.

PART E
COMPLETE FOR ALL FAMILY MEMBERS APPLYING FOR COVERAGE:

FIRST NAME	INITIAL	LAST NAME	APPLICANT	HEIGHT	WEIGHT	DATE OF BIRTH	SEX M/F
				/		/ /	
				/		/ /	
				/		/ /	
				/		/ /	
				/		/ /	
				/		/ /	

PART F
DETAILS TO HEALTH HISTORY

GIVE DETAILS OF EACH ITEM CHECKED (✔) ON THE FIRST PAGE IN A "YES" COLUMN OF PARTS B, C, D and E.
(If more space is needed, attach separate page which must be signed and dated.)

Question Number	Person Affected	Condition/ Diagnosis	Treatment (Surgeries/Medications)	Treatment Dates From	Treatment Dates To	Date of Full Recovery or Last Treatment Date	Name, Address, Phone Number of Physician, Hospital/Institution

To the best of my knowledge and belief, all of the information I provide is accurate and true. I understand that any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact may cause Anthem Blue Cross and Blue Shield to change my premium rate retroactive to my effective date or to terminate or void my coverage, in accordance with New Hampshire law.

Date_____

Applicant's Signature_____

Other Adult Signature (covered person 18 or older) _____

Payment Methods for Individual Health Coverage
New Hampshire

Anthem

Please complete in blue or black ink.

Applicant/Member Name (please print)	Primary Applicant's Social Security Number

INITIAL PREMIUM PAYMENT IS REQUIRED WITH APPLICATION. PLEASE CHOOSE ONE:

☐ Automatic Bank Payment (complete Section A).
If you choose this option, you must also select the Automatic Bank Payment option for future premiums.

☐ Check or Money Order attached
(make payable to Anthem Blue Cross and Blue Shield)*

*When you provide a check as payment, you authorize us to either use the information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use this information from your check to make an electronic fund transfer, funds will be withdrawn from your account as soon as the day of approval, and you will not receive your check back from your financial institution.

FUTURE PREMIUM PAYMENTS (MAKE ONE SELECTION OUT OF EACH COLUMN):

Frequency (you must select one):

☐ Monthly (available on either Method of Payment option)

☐ Quarterly (available on Bill Me Method of Payment option only)

Method of Payment (you must select one):

☐ Automatic Bank Payment (You must complete Section A).
Available on Monthly frequency.

☐ Bill Me for future premiums.
Available on Monthly or Quarterly frequency.

A. Automatic Bank Payment – If you have selected this option for your initial payment, your bank account may be debited the applicable month's premium as soon as the day of approval.
I hereby authorize Anthem Blue Cross and Blue Shield to initiate a withdrawal on or about the 5th business day of each month from the bank account named below. NOTE: Should your withdrawal not be honored by your bank, you will automatically be removed from Automatic Bank Payment and will be billed monthly.

☐ Checking Account

☐ Savings Account **(account number will be different than that of checking account)**. Check with your financial institution to be sure automatic recurring deductions are allowed against this account.

Provide your Bank Account Information here:

9-digit Bank Routing Number	Bank Account Number

I authorize Anthem Blue Cross and Blue Shield to initiate premium deductions (and corrections to premium deductions) from the bank account indicated, and the designated financial institution to debit the same account. **I understand that the initial premium amount may vary as a result of change(s) during the underwriting process and that following premium amounts may vary as a result of change(s) I make once enrolled**. These may include, but are not limited to, adding and deleting dependents or moving my residence. I understand that Anthem's rights with each premium deduction are the same as if I submit a check signed by me. This authorization is in effect until I provide Anthem thirty (30) days written notice that I no longer desire this service, and Anthem and the designated financial institution have the right to discontinue the premium deductions if they wish to do so.

I also understand that a service charge may be incurred for any withdrawal not honored.

Authorized Signature (as it appears on the financial institution's records)	Account Holder Name (please print)	Date
X		

PLEASE RETAIN A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS.

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